		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045047

Facility Name: THE MOORINGS HEALTH CENTER

Address: 761 OLD BARN LANE (Number) ARLINGTON HEIGHTS (City) 60005 (Zip Code)

County: COOK

Telephone Number: 847-364-2435 **Fax #** 847-956-4495

IDPA ID Number: 36-2167832001

Date of Initial License for Current Owners: 10/1/2000

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501C3

In the event there are further questions about this report, please contact:
Name: DAN CIROCK **Telephone Number:** 847-492-4871

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2004 to 03/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT E. LANDSMAN
(Title) VICE PRESIDENT OF FINANCE

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,680	3
4		Intermediate/DD			4
5	68	Sheltered Care (SC)	68	24,820	5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		15,055	3,888	18,943	8
9	SNF/PED					9
10	ICF	2,429	13,684		16,113	10
11	ICF/DD					11
12	SC		15,018		15,018	12
13	DD 16 OR LESS					13
14	TOTALS	2,429	43,757	3,888	50,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.97%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
ADULT DAY CARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 3,888

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 3/31/2005 Fiscal Year: 3/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	1,358,051	48,511	71,771	1,478,333		1,478,333	(857,433)	620,900			1
2	Food Purchase		1,140,130		1,140,130	(3,575)	1,136,555	(659,202)	477,353			2
3	Housekeeping	577,827	19,025	207,628	804,480		804,480	(547,046)	257,434			3
4	Laundry											4
5	Heat and Other Utilities			681,866	681,866		681,866	(463,669)	218,197			5
6	Maintenance	548,844	164,914	436,638	1,150,396		1,150,396	(852,530)	297,866			6
7	Other (specify):* PUBLIC SAFETY	252,366	3,921	34,059	290,346		290,346	(197,435)	92,911			7
8	**TOTAL General Services**	2,737,088	1,376,501	1,431,962	5,545,551	(3,575)	5,541,976	(3,577,315)	1,964,661			8
	B. Health Care and Programs											
9	Medical Director	73,034	14,420	45,101	132,555		132,555		132,555			9
10	Nursing and Medical Records	3,452,020	369,858	416,543	4,238,421	(184,232)	4,054,189		4,054,189			10
10a	Therapy	359,430	3,631	27,901	390,962		390,962		390,962			10a
11	Activities	316,440	21,571	92,296	430,307		430,307		430,307			11
12	Social Services	130,887	4,638	96,432	231,957	(98,798)	133,159		133,159			12
13	CNA Training	44,156	188	329	44,673		44,673		44,673			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,375,967	414,306	678,602	5,468,875	(283,030)	5,185,845		5,185,845			16
	C. General Administration											
17	Administrative	260,410	22,664	1,384,750	1,667,824	(179,422)	1,488,402	(640,684)	847,718			17
18	Directors Fees											18
19	Professional Services			43,041	43,041		43,041	(31,268)	11,773			19
20	Dues, Fees, Subscriptions & Promotions			71,680	71,680	199,586	271,266	(246,982)	24,284			20
21	Clerical & General Office Expenses	237,714	40,113	202,257	480,084		480,084	(477,154)	2,930			21
22	Employee Benefits & Payroll Taxes			2,175,295	2,175,295	3,575	2,178,870	(1,481,632)	697,238			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			19,249	19,249		19,249	(16,249)	3,000			25
26	Insurance-Prop.Liab.Malpractice			234,402	234,402		234,402	(161,156)	73,246			26
27	Other (specify):*	406,240	3,053	199,970	609,263		609,263	(898,705)	(289,442)			27
28	**TOTAL General Administration**	904,364	65,830	4,330,644	5,300,838	23,739	5,324,577	(3,953,830)	1,370,747			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,017,419	1,856,637	6,441,208	16,315,264	(262,866)	16,052,398	(7,531,145)	8,521,253			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number THE MOORINGS HEALTH CENTER #0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,723,824	1,723,824		1,723,824	(1,157,582)	566,242			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,725	47,725		47,725	(47,725)				32
33	Real Estate Taxes			5,639	5,639		5,639	(4,906)	733			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,777,188	1,777,188		1,777,188	(1,210,213)	566,975			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					164,068	164,068		164,068			39
40	Barber and Beauty Shops					98,798	98,798		98,798			40
41	Coffee and Gift Shops		2,530		2,530		2,530		2,530			41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,530	65,700	68,230	262,866	331,096		331,096			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,017,419	1,859,167	8,284,096	18,160,682		18,160,682	(8,741,358)	9,419,324			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (225,141)	27	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(64,301)	27		4
5	Telephone, TV & Radio in Resident Rooms	(37,683)	21		5
6	Rented Facility Space	(71,690)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(47,725)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(16,249)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,000)	19		22
23	Malpractice Insurance for Individuals	(1,763)	26		23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(180,672)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(18,914)	20		28
29	Other-Attach Schedule see page 5a	(8,075,221)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,741,359)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,741,359)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		98,798		41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		164,068		43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 262,866		47

STATE OF ILLINOIS

THE MOORINGS HEALTH CENTER

ID# **0045047**

Report Period Beginning: **04/01/2004**

Ending: **03/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	retirement expense dietary	$ (857,433)	1	1
2	retirement expense food	(659,202)	2	2
3	retirement expense housekeeping	(547,046)	3	3
4	retirement expense utilities	(463,669)	5	4
5	retirement expense maintenance	(782,269)	6	5
6	retirement expense public safety	(197,435)	7	6
7	retirement expense administration	(704,749)	17	7
8	retirement expense professional fees	(29,268)	19	8
9	retirement expense dues fees & subscriptions	(33,917)	20	9
10	retirement expense clerical	(439,471)	21	10
11	retirement side employee benefits	(1,481,632)	22	11
12	retirement side insurance	(159,393)	26	12
13	Adult day care & other retirement costs	(609,263)	27	13
14	retirement expense depreciation	(1,157,582)	30	14
15	retirement expense re taxes	(4,906)	33	15
16	deferred maintenance adj	1,429	6	16
17	Nurse Administrator salary add back	64,065	17	17
18	non allowable memberships & publications	(13,479)	20	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,075,220)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE MOORINGS HEALTH CENTER **#** 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(857,433)	0	0	0	0	0	0	0	0	0	0	(857,433)	1
2	Food Purchase	(659,202)	0	0	0	0	0	0	0	0	0	0	(659,202)	2
3	Housekeeping	(547,046)	0	0	0	0	0	0	0	0	0	0	(547,046)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(463,669)	0	0	0	0	0	0	0	0	0	0	(463,669)	5
6	Maintenance	(852,530)	0	0	0	0	0	0	0	0	0	0	(852,530)	6
7	Other (specify):*	(197,435)	0	0	0	0	0	0	0	0	0	0	(197,435)	7
8	**TOTAL General Services**	(3,577,315)	0	0	0	0	0	0	0	0	0	0	(3,577,315)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(640,684)	0	0	0	0	0	0	0	0	0	0	(640,684)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(31,268)	0	0	0	0	0	0	0	0	0	0	(31,268)	19
20	Fees, Subscriptions & Promotions	(246,982)	0	0	0	0	0	0	0	0	0	0	(246,982)	20
21	Clerical & General Office Expenses	(477,154)	0	0	0	0	0	0	0	0	0	0	(477,154)	21
22	Employee Benefits & Payroll Taxes	(1,481,632)	0	0	0	0	0	0	0	0	0	0	(1,481,632)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(16,249)	0	0	0	0	0	0	0	0	0	0	(16,249)	25
26	Insurance-Prop.Liab.Malpractice	(161,156)	0	0	0	0	0	0	0	0	0	0	(161,156)	26
27	Other (specify):*	(898,705)	0	0	0	0	0	0	0	0	0	0	(898,705)	27
28	**TOTAL General Administration**	(3,953,830)	0	0	0	0	0	0	0	0	0	0	(3,953,830)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,531,145)	0	0	0	0	0	0	0	0	0	0	(7,531,145)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number THE MOORINGS HEALTH CENTER **#** 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,157,582)	0	0	0	0	0	0	0	0	0	0	(1,157,582)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47,725)	0	0	0	0	0	0	0	0	0	0	(47,725)	32
33	Real Estate Taxes	(4,906)	0	0	0	0	0	0	0	0	0	0	(4,906)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,210,213)	0	0	0	0	0	0	0	0	0	0	(1,210,213)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,741,358)	0	0	0	0	0	0	0	0	0	0	(8,741,358)	45

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		MCGAW CARE CENTER	EVANSTON	PRESBYTERIAN HO	EVANSTON	HOME HEALTH
		BALMORAL CARE CENTER	LAKE FOREST	PRESBYTERIAN HO	EVANSTON	HOSPICE
		JAMES C. KING HOME	EVANSTON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		9	MEDICAL DIRECTOR	$ 474,722	PRESBYTERIAN HOMES	100.00%	$ 474,722	$	1
2	V		17	INFORMATION SYSTEMS	122,393	PRESBYTERIAN HOMES	100.00%	122,393		2
3	V		17	OVERHEAD ADMINISTRATION	2,246,965	PRESBYTERIAN HOMES	100.00%	2,246,965		3
4	V		17	MARKETING	642,244	PRESBYTERIAN HOMES	100.00%	642,244		4
5	V		17	ACCOUNTING SERVICES	332,551	PRESBYTERIAN HOMES	100.00%	332,551		5
6	V		17	HUMAN SERVICES	176,261	PRESBYTERIAN HOMES	100.00%	176,261		6
7	V		17	BOARD ADMINISTRATION	30,617	PRESBYTERIAN HOMES	100.00%	30,617		7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 4,025,753			$ 4,025,753	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 3/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PRESBYTERIAN HOMES
Street Address 3200 GRANT STREET
City / State / Zip Code EVANSTON, IL 60201
Phone Number (847-492-4871
Fax Number (847-570-3426

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	9	MEDICAL DIRECTOR	DIRECT COST	1		$ 474,722	$ 73,034		$ 0	1
2	17	INFORMATION SYSTEMS	DIRECT COST	1		122,393	69,681		0	2
3	17	OVERHAED ADMINISTRATIOI	DIRECT COST	1		2,246,965	137,797		0	3
4	17	MARKETING	DIRECT COST	1		642,244	236,997		0	4
5	17	ACCOUNTING SERVICES	DIRECT COST	1		332,551	209,269		0	5
6	17	HUMAN SERVICES	DIRECT COST	1		176,261	99,238		0	6
7	17	BOARD ADMINISTRATION	DIRECT COST	1		30,617	10,651		0	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,025,753	$ 836,667		$	25

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	PRESBYTERIAN HOME	X		IMPUTED INTEREST ON PURCHASE PRICE			$	$			$ 47,725	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 47,725	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 47,725	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number THE MOORINGS HEALTH CENTER **#** 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	114,043	2
3. Under or (over) accrual (line 2 minus line 1).	$	114,043	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	114,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	121,109	8
2001	160,565	9
2002	67,833	10
2003	109,502	11
2004	114,043	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE MOORINGS HEALTH CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045047

CONTACT PERSON REGARDING THIS REPORT DAN CIROCK

TELEPHONE 847-492-4871 FAX #: 847-570-2426

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-10-113-004-000	ASSISTED LIVING & HEALTH CAI	$ 114,043.00	$ 114,043.00
2.	08-10-113-003-000	RETIREMENT CENTER	$ 75,271.00	$
3.	08-10-113-002-000	RETIREMENT CENTER	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 189,314.00	$ 114,043.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,857 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories TWO

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Moorings of Arligton Heights: Retirement center 294 units, square footage, 325,616
All expenses related to the retirement center have been adjusted out based on 68% of the census residing in the retirement community.
All of the Adult Day Care costs have been adjusted out of the cost report.
Food service has been adjusted by 58% for retirement center.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		2000	$ 741,688	1
2					2
3	TOTALS			$ 741,688	3

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		2000	1994	$ 8,656,752	$ 249,178	35	$ 249,178	$	$ 1,122,221	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	JENSEN HALSTEAD ARCHITECTS			2001	2,796	280	10	280		1,260	9
10	PAYMENTS TO ADVOCATE			2002	10,724	306	35	306		1,071	10
11	FACILITIES MANAGEMENT			2002	16,844	1,684	10	1,684		5,894	11
12	DECORATING			2002	5,459	546	10	546		1,911	12
13	FLOORING			2002	5,011	501	10	501		1,754	13
14	CABLING, CAMERAS, SOUND SYSTEM			2002	16,165	1,616	10	1,616		5,656	14
15	POOL REPAIRS			2002	4,789	479	10	479		1,676	15
16	HEATING & VENTALATION			2002	13,303	1,330	10	1,330		4,655	16
17	CABINETS			2002	938	94	10	94		329	17
18	DOOR LOCKS			2002	705	71	10	71		248	18
19	SHELTERED CARE ARCHITECTS			2002	13,065	653	20	653		2,586	19
20	VILLA ARCHITECTS			2002	17,574	879	20	879		3,076	20
21	BUILDING SIDING			2002	150,792	7,540	20	7,540		26,390	21
22	ARCHITECTS STUDIES			2002	18,109	905	20	905		3,168	22
23	CABINETS			2002	448	22	20	22		77	23
24	FOOD SERVICE EQUIPMENT			2002	512	26	20	26		91	24
25	FACILITIES MANAGEMENT			2003	27,833	2,783	10	2,783		6,958	25
26	CABLING, CAMERAS, SOUND SYSTEM			2003	5,490	549	10	549		1,373	26
27	DECORATING			2003	20,475	2,048	10	2,048		5,120	27
28	FIRE ALARM SYSTEMN			2003	12,565	1,257	10	1,257		3,142	28
29	CABINETS			2003	36,787	1,839	20	1,839		4,598	29
30	ELECTRICAL WIRING			2003	42,505	2,125	20	2,125		5,313	30
31	HEATING & VENTALATION			2003	90,418	4,521	20	4,521		11,302	31
32	ARCHITECTS STUDIES			2003	52,552	2,628	20	2,628		6,570	32
33	ASBESTOS REMOVAL			2003	7,050	353	20	353		882	33
34	ARCHITECTS STUDIES			2003	120,149	6,007	20	6,007		15,018	34
35	MEDICARE WING CONST			2003	26,056	372	35	372		744	35
36	PAYMENTS TO ADVOCATE			2003	224,609	6,417	35	6,417		16,043	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING SIDING	2003	$ 94,416	$ 4,721	20	$ 4,721	$	$ 11,802	37
38	PAYMENTS TO ADVOCATE	2004	321,482	4,593	35	4,593		9,186	38
39	SIDING	2004	5,914	148	20	148		296	39
40	ROOF	2004	18,632	466	20	466		932	40
41	FACILITIES MANAGEMENT	2004	67,311	1,682	20	1,682		3,364	41
42	PLUMBING	2004	47,360	1,184	20	1,184		2,368	42
43	FLOORING/CARPETING	2004	23,097	577	20	577		1,154	43
44	CONSTRUCTION/RENOVATION - DEMOLITION, CORING, M	2004	162,145	1,621	50	1,621		3,242	44
45	ASBESTOS REMOVAL	2004	8,522	213	20	213		426	45
46	ARCHITECTS SERVICES	2004	60,429	1,511	20	1,511		3,022	46
47	ELECTRICAL UPGRADES	2004	8,817	220	20	220		440	47
48	HEATING AND VENTILATION	2004	16,000	400	20	400		800	48
49	ARCHITECTS SERVICES	2004	161,357	2,305	35	2,305		4,610	49
50	CONSTRUCTION/RENOVATION - ELECTRICAL, FIRE PROT	2004	1,472,060	5,193	50	5,193		10,386	50
51	ARCHITECTS SERVICES	2004	9,278	232	20	232		464	51
52	ROOF	2004	7,723	193	20	193		386	52
53	PLUMBING	2004	10,757	269	20	269		538	53
54	CONSTRUCTION/RENOVATION - WALL CHANNELING, SHC	2004	135,355	1,353	50	1,353		2,706	54
55	CABINETS	2004	10,479	262	20	262		524	55
56	MC WING RENOVATION	2004	7,379	369	10	369		738	56
57	PAYMENTS TO ADVOCATE	2005	303,421	15,171	10	15,171		15,171	57
58	FACILITIES MANAGEMENT	2005	78,442	3,922	10	3,922		3,922	58
59	ROOF	2005	29,520	1,476	10	1,476		1,476	59
60	CONSTRUCTION/RENOVATION -CERAMIC TILE, PAINTINC	2005	98,907	4,945	10	4,945		4,945	60
61	ARCHITECTS SERVICES	2005	6,367	318	10	318		318	61
62	ASBESTOS REMOVAL	2005	3,439	172	10	172		172	62
63	CONSTRUCTION/RENOVATION - STORM SEWER, PLUMBIN	2005	138,844	6,942	10	6,942		6,942	63
64	COSTRUCTION NEW VILLAS	2005	1,170,207	58,510	10	58,510		58,510	64
65	ARCHITECTS SERVICES	2005	24,566	1,228	10	1,228		1,228	65
66	CONSTRUCTION/RENOVATION - CARPENTRY, ELECTRIC/	2005	236,197	6,935	20	6,935		6,935	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 14,338,898	$ 424,140		$ 424,140	$	$ 1,416,129	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,041,360	$ 114,044	$ 114,044	$		$ 432,474	71
72	Current Year Purchases	55,872						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,097,232	$ 114,044	$ 114,044	$		$ 432,474	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUS	2001FORD	2002	$ 16,634	$ 28,058	$ 28,058	$		$ 42,207	76
77	BUS	2003 FORD	2003	32,285						77
78	BUS	2005 FORD	2005	94,681						78
79										79
80	TOTALS			$ 143,600	$ 28,058	$ 28,058	$		$ 42,207	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,321,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 566,242	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 566,242	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,890,810	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	RETIREMENT LAND	$ 1,576,086	$	$	86
87	RETIREMENT BUILDINGS	30,470,158	901,296	3,009,273	87
88	RETIREMENT EQUIPMENT	2,636,769	270,904	1,008,696	88
89					89
90					90
91	TOTALS	$ 34,683,013	$ 1,172,200	$ 4,017,969	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	65

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	5

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		517		517
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation		44,156		44,156
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 44,673	$	$ 44,673
10	SUM OF line 9, col. 1 and 2 (e)	$ 44,673			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				164,068		164,068	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 164,068		$ 164,068	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number THE MOORINGS HEALTH CENTER **#** 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 03/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,398,693		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	46,372		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,446,065	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,317,773		13
14	Buildings, at Historical Cost	44,809,055		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,877,602		16
17	Accumulated Depreciation (book methods)	(5,908,778)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CURRENT ACCOUNT	(2,064,465)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 43,031,187	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 44,477,252	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,129,397	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	425,309		28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED REVENUE	570,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,324,706	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	756,876		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	32,792,774		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,549,650	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 35,874,356	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,602,896	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 44,477,252	$	48

***(See instructions.)**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,479,470	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,479,470	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,123,426	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,123,426	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,602,896	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 20,070,103	1
2	Discounts and Allowances for all Levels	(298,082)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,772,021	3
	B. Ancillary Revenue		
4	Day Care	193,601	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 193,601	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	146,457	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	37,683	15
16	Rental of Facility Space	100,510	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 284,650	23
	D. Non-Operating Revenue		
24	Contributions	25,340	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,340	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	misc inc	8,496	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,496	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,284,108	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,545,551	31
32	Health Care	5,468,875	32
33	General Administration	5,300,838	33
	B. Capital Expense		
34	Ownership	1,777,188	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,160,682	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,123,426	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,123,426	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,116	2,591	$ 87,555	$ 33.79	1
2	Assistant Director of Nursing	1,860	2,080	66,535	31.99	2
3	Registered Nurses	35,066	36,978	1,013,027	27.40	3
4	Licensed Practical Nurses	6,996	7,307	155,310	21.25	4
5	CNAs & Orderlies	127,765	131,095	1,943,355	14.82	5
6	CNA Trainees					6
7	Licensed Therapist	10,226	11,640	290,654	24.97	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,535	4,000	85,140	21.29	9
10	Activity Assistants	15,186	16,346	199,084	12.18	10
11	Social Service Workers	5,286	5,898	124,409	21.09	11
12	Dietician					12
13	Food Service Supervisor	9,250	9,495	126,351	13.31	13
14	Head Cook	16,790	17,748	242,146	13.64	14
15	Cook Helpers/Assistants	63,324	66,698	552,822	8.29	15
16	Dishwashers	5,704	6,178	53,609	8.68	16
17	Maintenance Workers	28,269	30,210	519,923	17.21	17
18	Housekeepers	56,955	62,860	598,563	9.52	18
19	Laundry					19
20	Administrator	3,644	4,160	260,410	62.60	20
21	Assistant Administrator					21
22	Other Administrative	11,145	11,872	462,914	38.99	22
23	Office Manager					23
24	Clerical	21,274	22,937	350,642	15.29	24
25	Vocational Instruction	4,116	4,368	104,478	23.92	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,469	1,621	22,789	14.06	31
32	Other Health Care(specify)					32
33	Other(specify) Public Safety	38,844	41,169	757,703	18.40	33
34	TOTAL (lines 1 - 33)	468,820	497,251	$ 8,017,419 *	$ 16.12	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	480	45,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	2,000	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	530	$ 47,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,953	$ 297,649	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,953	$ 297,649		53

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Fitzgerald	Director	0	$ 166,197
Kathy Young	HCC Admin	0	94,213
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 260,410

B. Administrative - Other

Description	Amount
Overhead departments Accounting, Administration	$ 1,384,750
Marketing, Information services, Board Relations	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,384,750
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Malcolm James	Accounting	$ 14,944
Gardner, Carton & Douglas	Legal	19,999
Altheimer & Gray	Legal	501
Seyfarth, Shaw & Douglas	Legal	3,725
Deloitte & Touche LLP	Accounting	1,300
George M. Covington	Legal	2,572
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,041

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,031
Unemployment Compensation Insurance	443
FICA Taxes	182,626
Employee Health Insurance	243,836
Employee Meals	1,144
Illinois Municipal Retirement Fund (IMRF)*	
LTD	1,305
RETIREMENT	211,853
TOTAL (agree to Schedule V, line 22, col.8)	$ 697,238

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,422
Health Care Worker Background Check	1,250
(Indicate # of checks performed 125)	
INSPECTIONS & LICENSE	2,800
MEMBURSHIPS & PUBLICATIONS	8,812
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,284

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2004 Ending: 03/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING & DECORAT	3/2002	$ 32,638	3	$ 5,440	$ 10,879	$ 10,879	$ 5,440	$	$	$	$	$
2	APPLIANCES	3/2002	2,227	3	372	742	742	371					
3	HEATING & VENTALA	3/2002	42,129	5	4,213	8,426	8,426	8,426	8,426	4,212			
4	LOCK & KEY	3/2002	9,059	3	1,510	3,020	3,020	1,509					
5	FLOORING	3/2002	3,915	3	653	1,305	1,305	652					
6	OUTDOOR LIGHTING	3/2002	14,409	5	1,441	2,882	2,882	2,882	2,882	1,441			
7	SIDING	3/2002	3,900	3	650	1,300	1,300	650					
8	ELECTRICAL WIRING	3/2002	2,138	3	356	713	713	356					
9	HEATING & VENTALA	3/2003	43,053	5		4,305	8,611	8,611	8,611	8,610	4,305		
10	ELECTRACAL WIRING	3/2003	12,100	3		2,017	4,033	4,033	2,017				
11	PLUMBING	3/2003	15,080	3		2,513	5,027	5,027	2,513				
12	PAINTING & DECORAT	3/2003	3,750	3		625	1,250	1,250	625				
13	FOUNDATION	3/2003	4,170	4		521	1,043	1,043	1,043	520			
14	A/C & HEATING	3/2004	44,900	5			4,490	8,980	8,980	8,980	8,980	4,490	
15	ELECTRICAL WIRING	3/2004	4,530	3			755	1,510	1,510	755			
16	BOILER	3/2005	9,774	3				1,629	3,258	3,258	1,629		
17	HEATING & VENTALA	3/2005	30,680	5				3,068	6,136	6,136	6,136	6,136	3,068
18	ELEVATORS	3/2005	18,650	3				3,108	6,217	6,217	3,108		
19	A/C	3/2005	11,631	3				1,939	3,877	3,877	1,938		
20	TOTALS		$ 308,733		$ 14,635	$ 39,248	$ 54,476	$ 60,484	$ 56,095	$ 44,006	$ 26,096	$ 10,626	$ 3,068

Facility Name & ID Number THE MOORINGS HEALTH CENTER **#** 0045047 **Report Period Beginning:** 04/01/2004 **Ending:** 03/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,165** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,575** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **DELOITTE & TOUCHE** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.